

**Submission in response to the New National Women's Health Policy
Consultation Discussion Paper 2009.**

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I. Introduction

Focus of the submission

This submission will focus on the needs of lesbian, bisexual and same-sex attracted women. This is a disparate group of women however they are linked by being marginalised due to belonging to a minority sexual orientation. They tend to be particularly marginalised within health policy and health care in Australia, having been ignored within mainstream research and healthcare education. The submission will provide up-to-date and rigorous evidence of the health inequalities and specific health needs of these women, and outline the gaps in service provision that require focused policy attention.

Guiding framework

I agree with the framework established within the consultation discussion paper focusing on social inclusion and health inequalities. These factors are at the core of the specific health and wellbeing issues facing lesbian, bisexual and same-sex attracted women. I have based my submission on the premise that sexual minority women's health and wellbeing can only be optimised when health policy, research and practice move beyond the current liberal approach that disregards health differences within this minority group of women. This requires specific and overt reference to the health inequalities faced by these women, so I will suggest that they are added to the list of women who are particularly marginalised. I will use examples from my practice and my research and will highlight the gaps in service provision that need to be addressed.

Author's credentials and experience

I am an academic general practitioner. My practice and research interests include lesbian and bisexual women's health. For the past ten years I have worked in a private general practice that specifically markets to the lesbian and gay community and the majority of my clients are lesbian and bisexual women. I have also been involved in undergraduate and postgraduate education of health providers and give regular lectures on lesbian and bisexual women's health. I have conducted a range of research projects in the area including in lesbian sexual health, Pap testing and HPV, lesbian-parented families, and lesbian mental health. I have completed a PhD in 2009 on the patient-doctor relationship between same-sex attracted women and their usual GP. I have had 7 book chapters and 18 peer-reviewed papers published on lesbian and bisexual women's health.

I am also involved in a range of relevant community and policy organisations including:

- Victorian Ministerial Advisory Committee on GLBTI health and wellbeing
I have been a member of three iterations of this committee since its inauguration in 2000, and have just been appointed chairperson.
- Australian Lesbian Medical Association
I was a founding member in 1999 and was Convener from 2001-2004
- Rainbow Families Council
I was a founding member in 2006 and am currently the Treasurer
- Lesbian Health Board Advisory Committee, ACON, NSW 2008 to present

2. Principles to underpin the new policy

I agree with the five principles that are identified in the Consultation Discussion Paper as the basis for the development of the New National Women's Health Policy. I will briefly address the ways in which they apply to lesbian, bisexual and same-sex attracted women, and suggest that these connections require specific reference in the policy. This suggestion is in line with a recommendation within the Australian Women's Health Network submission (page 25) that vulnerable groups such as same-sex attracted women should be specifically addressed in each aspect of the policy.

a) Gender equity

The health issues for lesbian, bisexual and same-sex attracted women are distinct from those of gay and bisexual men and so require specific policy attention. They fit best within a women's health policy as they first and foremost relate to women's health rather than sexual health. Previous policy and health education inclusion of sexual minority women has, if anything, been only in the context of sexual health, and as a result lesbian and bisexual women's health has been overshadowed by gay men's health and particularly by HIV [need ref]. I will demonstrate below that the specific health inequalities encompass but travel well beyond the confines of sexual health.

An example of good policy – Canadian health policy inclusion

Canada has been developing lesbian health policy since the late 1990s. For example, a policy document was released following a project funded by Health Canada and the Status of Women Canada, which outlined key health issues and health services access that required specific attention [1]. Example recommendations include removing language from policy that is non-inclusive of lesbians and their partners, and ensuring that patients can define who they want to be involved in medical decision-making.

b) Health equity between women

Some lesbian, bisexual and same-sex attracted women are subject to avoidable yet major health inequalities that are equivalent to those of some ATSI, immigrant, refugee, homeless,

rural and disabled women. I will present the evidence for these inequalities below, but in summary they include:

- delayed attendance or lack of continuity at health services due to fear of negative attitudes
- difficulty with disclosure of sexual orientation when desired due to uncertainty regarding possible responses and subsequent cultural sensitivity
- stress related to disclosure of minority sexual orientation (coming out) due to potential/actual loss of family/peer/collegial support
- greater likelihood of experiencing violence and harassment including sexual or physical assault
- increased rates of mental health problems by at least 2 to 3 times population levels
- increased rates of self-harm and suicidality
- increased rates of smoking, harmful alcohol and illicit drug use amongst sub-groups
- lower levels of cervical, breast and cardiovascular screening
- higher risk of breast, cervical and ovarian cancers as a result of lower pregnancy rates, higher smoking and reduced rates of screening
- poorly recognised risks for sexually transmissible infection and limited safer sex usage

Further, sexual minority women can have multiple inequalities due to multiple minority status, for example, being lesbian and aboriginal, or same-sex attracted and homeless, or being a bisexual immigrant in a rural area living with a disability. Therefore, I recommend that lesbian, bisexual and same-sex attracted women should be added to the list of women who are subject to major health inequalities. Adding them at this level of policy will enlighten health care providers who are currently largely ignorant of these issues.

An example of good policy – Victorian Department of Health Guide to inclusive practice

The Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Health and Wellbeing in Victoria has undertaken a review of the literature and widespread consultations to develop a guide to inclusive practice for Department of Health funded services [2 Transgender and Intersex Health and Wellbeing, 2009]. This is to be launched in December 2009 and will then be available on the DH website (www.health.vic.gov.au/glbti/mac). This document outlines the specific needs of GLBTI people, how mainstream health services can be inclusive, as well as providing recommendations for targeted health services such as drug and alcohol, mental health, housing, rural, residential, family, and disability services. This is the first such policy document of its kind in Australia and provides much needed evidence-based guidance for health and community service providers

and managers. However, there are many more gaps to fill including policy that applies to federally funded and private health services.

c) Prevention

Prevention is relevant to lesbian, bisexual and same-sex attracted women for two major reasons. The first is that there is evidence of lower screening rates amongst this group compared with heterosexual women and so there is a pressing need for targeted health promotion. Second, sub-groups of sexual minority women are at risk due to particular lifestyles that are common within the lesbian and gay community. These relate to high levels of substance use within the lesbian and gay party and club scene and subsequent sexual risk taking and mental health sequelae. There is evidence that lesbian, bisexual and same-sex attracted women do not respond to mainstream (heterosexual) health promotion messages in the areas of substance use [3] or sexual behaviour [4] and so need targeted approaches.

A further area that urgently requires targeted prevention strategies is youth suicide. This is not specifically a women's health issue, and the policy initiatives here sit best within the national suicide prevention framework. Excellent work with same-sex attracted young people has started as a result of their inclusion as a specific risk group.

Examples of targeted health promotion initiatives for sexual minority women

There are just a few initiatives in Australia. These include the Pap screen Victoria cervical screening promotion to lesbians to improve screening uptake in this group. In NSW, GLBTI peak body ACON has developed drug and alcohol initiatives to promote safer substance use amongst GLBTI subgroups. Another example is the work of Way Out Rural Victorian Youth and Sexual Diversity Project (www.wayout.org.au). This provides support for same-sex attracted rural youth and specifically addresses suicide prevention strategies in this group through encouraging social connection.

d) Evidence base

There is an emerging evidence base in the area of sexual minority women's health including population-based studies in most Western English-speaking countries that reveal significant health inequalities [5]. This evidence has been obtained by specifically adding sexual orientation questions to national survey instruments. Rigorous international examples include the US National Health Interview Survey (n = 93,418, including 614 women in same sex relationships) [6], and a Canadian national probability survey on health care use (n = 83,723 heterosexual, 695 lesbian, and 833 bisexual women [7]. The Australian Longitudinal Study of Women's health (ALSWH) has included a sexual orientation question in two of the young cohort surveys (2000 and 2003) and one of the mid aged cohort surveys (2001). I have led two research teams that have conducted analysis on these survey results and have found

highly significant differences in mental health, substance use and physical health according to sexual orientation [8, 9]. Each of the three cohorts contains over 8,000 women, however the older cohort surveys have not included this question. The sexual orientation question is

Which of these most closely describes your sexual orientation?

- a) I am exclusively heterosexual,
- b) I am mainly heterosexual,
- c) I am bisexual,
- d) I am mainly lesbian/gay,
- e) I am exclusively lesbian/gay, or
- f) I don't know.

Further, the 2007 National Survey of Mental Health and Wellbeing by the Australian Bureau of Statistics (n=8,800) has now incorporated sexual orientation, which again shows significant disparities in mental health of sexual minority women.

Although there is emerging research, there are many gaps in research in this area that should be highlighted by the National Women's Health Policy as priorities for future research. These gaps include:

- A lack of sexual orientation questions in the majority of national datasets, in particular the Australian Census, which prevents the collection of comparative data on a wide range of health indices. For example, currently the census records the gender of the domestic partner who is cohabiting, but does not record single sexual minority people and those in same-sex relationships who do not cohabit. There is also no opportunity to record sub-groups of sexual minority such as bisexual or same-sex attracted people.
- There are many unanswered questions regarding the underlying reasons for many of the health inequalities amongst sexual minority women such as the higher rates of sexual abuse, and higher rates of depression. While assumptions are made that experiences of discrimination and harassment are linked, research is needed that specifically explores the causative relationship between discrimination and health outcomes. Another example is the role that identity and social connectedness plays in any differences between heterosexual and sexual minority women.
- There is a need for a clearer distinction to be made between sub-groups of sexual minority women, as there is emerging evidence of greater health inequalities amongst certain subgroups such as same- sex attracted youth, bisexual women, and mainly heterosexual women. There is also a need to distinguish between those with minority sexual identity, attraction and behaviour, which require the use of multiple sexual orientation measures rather than just one measure.
- Translation of evidence to clinical practice is urgently needed. I will demonstrate below that health care providers have limited or no knowledge regarding sexual

minority women's health due to a lack of inclusion in training and difficulty accessing existing research evidence.

- There is a need to evaluate the impact of targeted health promotion messages on sub-groups of sexual minority women, and also to evaluate the impact of specific healthcare provider education programs on culturally competent service provision.

e) A lifecourse approach

A lifecourse approach is applicable to lesbian, bisexual and same-sex attracted women as there are risk factors relating to sexual orientation at various lifestages that have impacts on health and wellbeing. These risk factors should be explicitly mentioned within the women's health policy in order to be addressed. Adolescence is a time when many same-sex attracted young people first realise their attractions. The nature of the responses to coming out amongst family, school and peers play a huge role in wellbeing at this lifestage. Coming out at any age can be associated with other risk factors such as substance use, and yet services that support drug and alcohol withdrawal are rarely well equipped to deal with minority sexual orientation. In adult life, sexual minority women are found to form their significant relationships later than heterosexual peers, which can create risks related to social isolation and limited social support. Forming family is a difficult transition for many lesbian women as they must negotiate a sometimes hostile and often ignorant health care system to access reproductive services and advice. A risk here is that some women may arrange self-insemination with known donors to avoid the system, and in the process not receive adequate health advice and screening. Finally, death or frailty of a same-sex partner is a time of vulnerability for many older women as they must negotiate a difficult course between disclosure of their previously concealed relationship or loss of support if they remain silent.

Example of good practice in counselling for life transitions- Drummond St Relationship Centre in Melbourne

This counselling service has developed specific programs for gay, lesbian and same-sex attracted individuals and couples. It has also provided regular in-service training for the staff on GLB sensitivity. This provides a good example of a service response to a specific community need, with adequate preparation of staff for cultural competency.

3. Existing research evidence

International population-based studies indicate a prevalence of lesbian and bisexual identity of around 1.5% of women, with up to 8% of women reporting same-sex desire or behaviour

[10-12]. There is an increasing evidence base that same-sex attracted women experience significant health inequalities compared to heterosexual women [5]. This is thought to be predominantly related to the socio-political climate of ongoing homophobia creating discrimination and social exclusion, which can result in increased levels of mental health problems, experiences of abuse, drug use and other risk taking behaviours. I will summarise the literature outlining these health disparities. I have also included a table from a submitted paper of results from the young women's cohort of ALWHS comparing health status according to sexual orientation.

Mental health

There is convincing evidence from several international population-based studies that lesbian and bisexual women have higher rates of depression, anxiety and suicidal ideation than heterosexual women. These studies are from the USA [13], the Netherlands [14], New Zealand [15] and Australia [8]. The ALSWH also reveals that lesbian and bisexual women have twice the likelihood of experiencing all forms of abuse over their lifetime compared with heterosexual women [8].

Substance use

Drug and alcohol use is reported to be higher amongst lesbian and particularly bisexual women in several large studies in the UK [16], the Netherlands [17], the USA [18] and Australia [19], and is thought to occur at least partly as a coping mechanism against discrimination. Substance abuse in turn increases the risk of sexual and other risk taking activities [16, 18].

Preventive care

Lesbian and bisexual women are also less likely to access preventative screening. Reduced cervical, breast and cardiovascular screening rates have been found in several population-based USA studies [20-22]. One comparative study of 1,284 women attending USA primary care services showed that bisexual women were less likely than heterosexual or lesbian women to have lipid or mammogram screening [23]. Screening rates have not been reliably compared in the UK and Australia, although they are also lower in Canada [7].

Physical health issues

There is concern that lower screening rates coupled with higher risk factors will, for example, increase certain cancers and cardiovascular disease amongst same-sex attracted women [20, 24]. There is some evidence suggesting higher rates of sexually transmissible infections (STI) amongst bisexually active women [16], and higher levels of heart disease amongst lesbians [21]. Sandfort et al (2006) found that lesbian and gay adults were more likely than heterosexual adults to report acute physical symptoms and chronic physical conditions, although when mental health status was controlled, only chronic conditions were significantly different. I present data from the ALWHS on health status in Table 1 below.

Table 1: Health status indicators by sexual identity ALWHS Young Cohort survey 3, 2003 {McNair et al, Submitted 2009}

| | Heterosexual n = 7430 M (SD) | Mainly Heterosexual n = 548 M (SD) | Bisexual n = 84 M (SD) | Lesbian n = 85 M (SD) | Statistical test |
|---|------------------------------------|---|------------------------------|-----------------------------|--------------------------------------|
| Health status | | | | | |
| Short term Physical Functioning (0-100) | 91.2 (15.3) | 90.1 (15.5) | 88.0 (15.8) | 92.5 (14.7) | Ns |
| Current General Health (1-5) | 2.37 (.85) | 2.54 (.91) | 2.79(1.03) | 2.49 (.95) | F _(df= 3, 8450) =14.35*** |
| Short Term Mental Health (0-100) | 71.0 (16.7) | 66.48 (18.9) | 64.1 (18.4) | 67.1 (18.8) | 17.6*** |
| Stress (0-4) (previous year) | .88 (.51) | 1.10 (.62) | 1.34 (.69) | 1.04 (.54) | 53.0*** |
| Current Life Satisfaction (1-5) | 3.3 (.42) | 3.1 (.48) | 3.0 (.51) | 3.2 (.42) | 33.6*** |
| Diagnosed in last 3 years (as %) | | | | | |
| | % | % | % | % | Statistical test |
| Abnormal Pap test | 24.3 | 33.2 | 42.4 | 16.2 | 56.8*** |
| Asthma | 9.8 | 15.7 | 18.0 | 10.4 | 26.3*** |
| UTI | 17.7 | 22.9 | 28.0 | 7.3 | 23.6*** |
| STI | 3.7 | 9.1 | 7.0 | 3.1 | 41.1*** |
| Hep B or C | 0.2 | 0.5 | 4.0 | 0 | 62.4*** |
| Cancer | 1.1 | 2.7 | 1.0 | 3.1 | 15.0* |
| Depression | 11.2 | 25.4 | 34.0 | 25.0 | 151.7*** |
| Anxiety | 5.5 | 10.9 | 20.0 | 14.6 | 73.0*** |
| Short Term CES-D \geq 10 | 24.5 | 33.9 | 44.4 | 28.6 | 44.2*** |

* p<.05 ** p<.01 ***p<.001

^a The diagnoses with significant differences are shown. Other diagnoses with non-significant differences were all forms of diabetes, heart disease, hypertension, low iron and endometriosis.

Health care usage

Health care access varies according to country and the health care system studied. Data from the US National Health Interview Survey (n = 93,418) showed that women in same sex relationships (n=614) were about one-half as likely than women in heterosexual relationships to have seen a doctor in the previous 12 months or to have a regular source of care [6].

Barriers to accessing US health services have been summarised as: limited health insurance and next of kin rights, inadequate number of providers competent in minority sexual orientation issues, lack of specific prevention services, and preference not to disclose sexual orientation [5]. A Canadian national probability survey compared health care use in 83,723 heterosexual, 695 lesbian, and 833 bisexual women and also found that lesbians were less likely to see a GP in the previous 12 months and less likely to have a regular doctor [7]. By contrast, lesbian and bisexual women were *more* likely to see a mental health care provider than were heterosexuals in the Canadian study [7], and this was also found in a population-based Californian study [25]. Conversely, a large Dutch survey (n = 9,684 patients, 1.5% lesbian and 1.2% bisexual women), showed that 'homosexuals' had a *higher* usage of physical and mental health care services [26].

Australian data from the ALWHS young women aged 25-30 (exclusively heterosexual 8,083, 91.3%; mainly heterosexual 568, 6.4%; bisexual 100, 1.1%, and lesbian 99, 1.1%) shows that lesbian, bisexual and mainly heterosexual women were significantly more likely than were heterosexual women to have used health services; but had lower continuity of GP care and lower satisfaction with that care {McNair, submitted}.

Satisfaction with health services

Levels of satisfaction with health care are consistently found to be lower for lesbian and bisexual women than heterosexual women [7, 21]. Reasons for dissatisfaction often relate to difficulty accessing health care, [21, 27], and unmet healthcare needs [7]. Poor communication by providers including assumptions of heterosexuality is also implicated [28]. Dissatisfaction can result from, or lead to, reluctance to disclose sexual orientation [29]. Conversely, satisfaction with health care is found to be higher when providers and services are more culturally competent regarding minority sexual orientation [5, 30, 31].

Lesbian and bisexual women's sensitive health care

Several studies have shown an association between disclosure of sexual orientation and improved satisfaction [32-34]. This satisfaction has been attributed to more culturally sensitive communication [35, 36], and is associated with increased disclosure of other sensitive issues including STI risks and substance abuse [32]. A comprehensive definition of lesbian and bisexual women's sensitive health care and lesbian-specific cultural competence is that providers are [37-39]:

- comfortable with treating lesbians and bisexual women
- receptive and inclusive of women's partners
- knowledgeable of common concerns such as ageism, sexuality and reproduction
- aware that health concerns could differ from those of heterosexual women, particularly relating to socio-political issues and the impact of discrimination
- understand the significance of documenting sexual orientation in their notes and would obtain permission from their lesbian patients to do so
- know about specific community resources

Health care provider knowledge

Most doctors state that they have not received adequate formal education about lesbian health [40-42]. Difficulty accessing information about lesbian and bisexual women's health begins in medical school and continues throughout their career. To date, there has been no national audit of lesbian health teaching in Australia. National reviews of gay and lesbian undergraduate course content in the USA [43, 44], Britain [45], and Canada [46] reveal limited time allocation and poorly integrated teaching regarding lesbian and gay health issues, with a tendency to teach about sexual orientation within an illness framework. All authors conclude that the topic is marginalised and that teaching and learning about homosexuality should be integrated throughout medical curricula.

Lesbian and bisexual women's health has also been absent in Australian general practice training. The first time these issues were formally included in the RACGP curriculum was in 2007. General practice texts have traditionally not included specific information, for example, the recommended text in Australia first included information on lesbian health in its fourth edition in 2007 [47]. Australia's most recent text on women's health in general practice has only two references to lesbian health, one regarding lesbian women's need for pap smears and the other on the sexual transmission of bacterial vaginosis between women [48].

4. Current Health Service and Policy Responses

There are several examples of international and state-based initiatives in culturally sensitive health services and policy that can serve as a benchmark for the national women's health policy. One such example is the Victorian Department of Health guide mentioned above. Another example in Victoria, is a recently funded initiative by the Victorian Government to undertake anti-homophobia community education to reduce the incidence of homophobic violence. Further, Gay and Lesbian Health Victoria is a state-government funded service formed in 2004 (<http://www.glhv.org.au>). The role of the unit is to "enhance and promote the health and well being of GLBTI people in Victoria". This is done by:

- training health care providers and health organisations about GLBTI health needs and appropriate service delivery

- developing health resources for GLBTI communities, in conjunction with mainstream services
- establishing a research and information clearinghouse as a resource for health care providers, researchers and individuals to use in researching their own health issues
- providing advice to Government on the planning and development of future GLBTI programs.

Such initiatives are needed in each Australian state and territory and it would seem logical to develop a federal response to these issues that could filter through to states and territories.

Internationally, the NHS Scotland conducted an extensive process of consultations to develop their policy on GLBT health during the mid 2000s [49]. This has since been affirmed by the UK Equalities Act 2006, which requires that lesbian, gay and bisexual staff and patients are fully included in health and social care. This policy is based on a model of social inclusion and explicitly states that health care providers must be culturally competent for effective GLBTI patient care.

5. Priorities for the new National Women's Health Policy

I will focus on one of the priorities stated in the discussion paper (2009), which is the development of culturally appropriate frameworks. This applies very well to lesbian, bisexual and same-sex attracted women. I will then summarise the other priorities arising from the evidence that I recommend should be in the new policy.

Encourage the health system to be more responsive to the needs of sexual minority women using culturally appropriate frameworks

Examples are given in the discussion paper of cultural respect framework for ATSI health, and for immigrant and refugee women. This should be equally applied to lesbian, bisexual and same-sex attracted women. Cultural competence has been used as a framework for policy and healthcare provider education regarding lesbian, gay and bisexual health particularly for the past decade [49-52]. More recently, it was an underlying principle within the Victorian Ministerial Advisory Committee on Gay and Lesbian Health Action Plan, the first proposed specific health policy in Australia [53]. The argument in this application is that if health policy and healthcare providers can develop a better awareness of the cultural aspects of sexual minority health such as the social connections and impacts of discrimination then the care can be more sensitive and appropriate. This requires not only inclusive policy but also targeted healthcare provider education at all levels.

Recommendations on specific priorities to ensure inclusion of sexual minority women

- Lesbian, bisexual and same-sex attracted women should be added to the list of women who are subject to major health inequalities. Adding them at this level of policy will enlighten health care providers who are currently largely ignorant of these issues.
- Targeted health promotion should be encouraged for sexual minority women in areas in which they are under-screened: cervical screening, breast screening and cardiovascular risk screening. Targeted health promotion is also required for risk behaviours to reduce STI transmission, substance misuse, self harm, mental health problems.
- Sexual orientation questions should be added to national datasets, in particular the Australian Census. These should encompass sexual identity, sexual behaviour and sexual attraction to enable accurate data collection and comparison of health and wellbeing status between sexual orientation groups.
- Health care provider education and sensitivity training should be encouraged within health services regarding sexual minority women's health. This would include building knowledge on specific health issues and skills for culturally competent care.
- Research should be prioritised and funded, specifically focused on reasons underlying the health disparities amongst sexual minority women including the impact of discrimination and marginalisation.
- General community anti-homophobia education should be considered with a view to reducing homophobic violence and vilification towards sexual minority women.

Finally, I recommend the formation of a federal advisory group on sexual minority health and wellbeing issues to inform government policy, health services responses and research regarding these many priority issues. This has been a highly successful approach in Victoria. The Ministerial Advisory Committee on Gay and Lesbian Health was formed in 2000 and is now in its third three-year term. I have been on the committee since its inception and have been involved in a profound shift in awareness at a state policy level that started with a complete silence on GLBTI issues. This progressed to the development of an action plan in 2003 [53], which resulted in significant funding to establish Gay and Lesbian Health Victoria (GLHV). GLHV has become a peak body for the dissemination of GLBTI health information via its Clearinghouse, for responses to health care providers and consumers, and for the initiation of research. The work of the advisory committee has now culminated in the development of the Guide to inclusive practice, which is about to be launched. We plan to evaluate its impact within state-funded health services during 2010.

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